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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3250 CERTIFICATE OF DEATH

03223

Reg. Dist. No. 252

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>QUEEN ANNE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CHESTER</u>		<u>LIFE</u>		TOWN <u>CHESTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>MARY</u> (Middle) <u>ELIZABETH</u> (Last) <u>BENTON</u>				<u>MARCH 8</u> <u>1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>F</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>NOV. 2, 1855</u>	<u>100</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HOUSEWIFE RET.</u>		<u>HOUSEWORK</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>SAMUEL W. JONES</u>				<u>SARAH A. THOMPSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>NONE</u>		<u>MISS ANNIE BENTLEY, CHESTER, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>450.0 IMMEDIATE CAUSE</b> (A)				<u>hypertension</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Chr. Enterocolitis</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B)							
<b>DUE TO</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 10 1936</u> , to <u>March 8 1956</u> , that I last saw the deceased alive on <u>March 8, 1956</u> , and that death occurred at <u>                    </u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Chas E J. Funder</u> M.D.				<u>Stevensville</u>		<u>3/8/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) <b>(State)</b>	
<u>BURIAL</u>		<u>MAR. 10 '56</u>		<u>KINGSLEY CHURCH</u>		<u>CHESTER, MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>MAR 12 1956</u>		<u>Mrs. E. J. Funder</u>		<u>W. Thompson</u>		<u>EASTON, MD.</u>	

# 1950 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF STATE ATTORNEY

24. SIGNATURE OF ATTORNEY GENERAL

25. SIGNATURE OF SECRETARY OF STATE

26. SIGNATURE OF COMMISSIONER OF DEPARTMENT OF HEALTH

27. SIGNATURE OF DEPUTY COMMISSIONER

28. SIGNATURE OF ASSISTANT COMMISSIONER

29. SIGNATURE OF CHIEF OF BUREAU

30. SIGNATURE OF CLERK

31. SIGNATURE OF RECEPTIONIST

32. SIGNATURE OF MAIL ROOM

33. SIGNATURE OF TELEPHONE ROOM

34. SIGNATURE OF RECORDS SECTION

35. SIGNATURE OF STATISTICS SECTION

36. SIGNATURE OF INSPECTION SECTION

37. SIGNATURE OF LABORATORY SECTION

38. SIGNATURE OF RADIATION SECTION

39. SIGNATURE OF VETERINARY SECTION

40. SIGNATURE OF ZOOLOGICAL SECTION

41. SIGNATURE OF BOTANICAL SECTION

42. SIGNATURE OF AGRICULTURAL SECTION

43. SIGNATURE OF FOREST SECTION

44. SIGNATURE OF GAME SECTION

45. SIGNATURE OF FISH SECTION

46. SIGNATURE OF WILDLIFE SECTION

47. SIGNATURE OF MARINE SECTION

48. SIGNATURE OF AQUARIUM SECTION

49. SIGNATURE OF ZOO SECTION

50. SIGNATURE OF BOTANICAL GARDEN SECTION

51. SIGNATURE OF HERBARIUM SECTION

52. SIGNATURE OF MUSEUM SECTION

53. SIGNATURE OF LIBRARY SECTION

54. SIGNATURE OF ARCHIVES SECTION

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251. SIGNATURE OF BOTANICAL SECTION

3251

## CERTIFICATE OF DEATH

Reg. Dist. No.

03224

1. PLACE OF DEATH o. COUNTY <u>Queen Annes</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u> 48x.3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walraven Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY G. BLACKWELL</u>				4. DATE OF DEATH Month Day Year <u>March 22 19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1865</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>instructor Supervisor-Languages</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Smithfield, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Dunn Blackwell</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Folk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Mrs. Austin F. Roberts, Sudlersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Primal Cerebral Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1954</u> , to <u>June 22, 1956</u> , that I last saw the deceased alive on <u>March 21, 1956</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sudlersville, Md. 3/23/56</u>			
PHYSICIAN'S NAME (Type) <u>C. H. Metcalfe</u>				<u>Sudlersville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March, 26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithfield, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Mar. 23</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		1956		BOSTON	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
MARRIED		1950		BOSTON		1956		BOSTON		1956	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		1956		BOSTON		1956		BOSTON	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		JAMES J. JONES		1956		BOSTON		1956		BOSTON	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1956		BOSTON		1956		BOSTON		1956		BOSTON	

BUREAU V. S.

MAR 27 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3252

## CERTIFICATE OF DEATH

03225

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>				c. LENGTH OF STAY IN 1b <u>6 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs. Skinner's Nursing Home</u>				d. STREET ADDRESS <u>14X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>H?</u> Last <u>Davies</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1867</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>	IF UNDER 24 HRS. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>(by marriage U.S.A.)</u>	
13. FATHER'S NAME <u>Benjamin Davies</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>H. Morris Davies</u>		Address <u>Worton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Cirrhosis of Liver</u> DUE TO (b) <u>Starvation</u> DUE TO (c) <u>Starvation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 9, 1956</u> , to <u>Mar 13, 1956</u> , that I last saw the deceased alive on <u>Mar 13, 1956</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. P. Atwell</u>		M.D. <u>Still Pond Md</u>		DATE SIGNED <u>3/13/56</u>			
PHYSICIAN'S NAME (Type) <u>L. P. Atwell, M.D.</u>		ADDRESS (Street, city or town, state) <u>Still Pond, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's (Longgreen)</u>		22d. LOCATION (City, town, or county) (State) <u>Hyde - Balto. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR <u>3/14</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar D. Lane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03226

3253 **CERTIFICATE OF DEATH**

Reg. Dist. No. 252

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>QUEEN ANNE'S</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>QUEEN ANNE'S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL CENTREVILLE</u>		LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL CENTREVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Adolph Traugott Doehler</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAR. 4 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 6, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Francis Doehler</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Jacobs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mr. J. Fred Stett Doehler, Centerville, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
451X IMMEDIATE CAUSE (A) <u>Dissecting Aortic Aneurysm</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Artero Sclerosis Aorta</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 4, 1956</u> , to <u>March 4, 1956</u> , that I last saw the deceased alive on <u>March 4, 1956</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. H. Roston</u>				ADDRESS (Street, city, town, state) <u>Centerville</u>		DATE SIGNED <u>3-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Christyfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>	
24. REC'D BY REGISTRAR <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Elvie Armstrong</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Benton Jr.</u>		ADDRESS <u>Centerville, Maryland</u>	

# CERTIFICATE OF DEATH

Form No. 10-58

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

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40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

BUREAU V. S.

MAR 12 1956

RECEIVED



**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE	
PREVAILING DISEASE		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF JURY		SIGNATURE OF JUDGE	

BUREAU V. S.

APR 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04394

3255

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GEORGE WASHINGTON HORNEY</u>		4. DATE OF DEATH <u>Mar. 29 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12 - 1870</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Horney</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Amos Horney</u>	
17. INFORMANT <u>Amos Horney</u>		Address <u>Chester Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO <u>myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general &amp; cerebral</u> (c) <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>March 29, 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ind.</u>		20f. (City or town) <u>Ind.</u> (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1956</u> , to <u>March 29, 1956</u> , that I last saw the deceased alive on <u>March 28, 1956</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.		DATE SIGNED <u>Mar 3/29 56</u>	
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar. 31</u>		22b. DATE THEREOF <u>Stevensville</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) <u>Ind.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		ADDRESS <u>Church Hill, Ind.</u>	
24a. REC'D BY REGISTRAR <u>April 6 - 56</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>	

BUREAU V. S.

APR 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3256

## CERTIFICATE OF DEATH

03228

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>K.</u> Last <u>Hynson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1955</u>
9. AGE (In years last birthday) yrs. <u>10</u> Months <u>10</u> Days <u>15</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hynson</u>		14. MOTHER'S MAIDEN NAME <u>Bertha May Denby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Hynson--Centreville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchio Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chicken Pox</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>2 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12, 1956</u> , to <u>March 13, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. R. Layton</u> M.D. <u>Centreville Md</u> <u>3-13-56</u> PHYSICIAN'S NAME (Type) <u>C. R. Layton</u> <u>Centreville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 14</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roesville</u>		22d. LOCATION (City, town, or county) (State) <u>Near Centreville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>3-13</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	



# CERTIFICATE OF DEATH

6258

BUREAU V. 2

MAR 20 1956

RECEIVED

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. PLACE OF DEATH                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>12. SIGNATURE OF WITNESS                  [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>14. SIGNATURE OF CORONER                  [Faint text]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICE IN THE CITY OR TOWN WHERE THE DECEASED RESIDED AT THE TIME OF DEATH.

3257

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POND TOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GOLTS</u> <u>14 x - 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HANNAH E. JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 6 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE - 25, 1883</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOSEPH MARTIN</u>			
14. MOTHER'S MAIDEN NAME <u>HANNAH LEE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>222-20-0411</u>				17. INFORMANT Address <u>MRS. VIOLE COMEGYS - MILLINGTON-MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Hardening of the arteries -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks -</u> <u>2</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 31</u> , 19 <u>55</u> , to <u>March 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>56</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geza Koralewski</u>				ADDRESS (Street, city or town, state) <u>Millington, Md.</u>			
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>				DATE SIGNED <u>3.8.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHEL - CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GOLTS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-9</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		GUNSHOT WOUNDS		DR. JAMES H. HARRIS	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		HISTORY OF DRUGS	
CONTRACTOR		HIGH SCHOOL		METHODIST		SINGLE		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		LABORATORY DATA		X-RAY DATA		PATHOLOGICAL DATA	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
NONE		NONE		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

MAR 20 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03230

3258

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

<b>1. PLACE OF DEATH</b> a. COUNTY <u>QUEEN ANNE</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u>				c. LENGTH OF STAY IN 1b <u>14x-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>HARRY</u> Middle <u>MERRILL</u> Last <u>MERRILL</u>				<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March &amp; day 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OYSTERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHUCKER</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-03-3851-A</u>		17. INFORMANT <u>MARY POTTS.</u> Address <u>MILLINGTON, MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Cardio Renal Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 12, 1955</u> to <u>Mar 6, 1956</u> , that I last saw the deceased alive on <u>March 2, 1956</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Hamilton</u> M.D. <u>Millington Md</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/8/56</u>			
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RILEYS NECK, CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PURDL MILLINGTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows-</u> ADDRESS <u>Millington Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-9</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

# CERTIFICATE OF DEATH

11528

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

11528

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
AGE [Illegible]		SEX [Illegible]	
MARRIAGE [Illegible]		OCCUPATION [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE [Illegible]		DATE [Illegible]	

BUREAU V. S.

MAR 20 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3259 CERTIFICATE OF DEATH

03231

251

Reg. Dist. No. ....

Item 4. Film G194 3-22-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Barclay</u>				TOWN <u>Barclay</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Annae Legg Phillips</u>				<u>March 6, 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Fem.</u>	<u>White</u>	<u>Widowed</u>	<u>Nov. 10-1861</u>	<u>94</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Housewife</u>					<u>Maryland</u>		<u>USA</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Thomas Legg</u>				<u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
					<u>Bembert Phillips--Barclay, Md.</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>170x IMMEDIATE CAUSE (A)</b>						INTERVAL BETWEEN ONSET AND DEATH	
<u>Carcinoma of Breast</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B) DUE TO</b>							
<u>Cachexia</u>							
<b>(C) DUE TO</b>							
<u>Chronic myeloid leukemia</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>Leukemia</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>2-10</u>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<input type="checkbox"/>							
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb. 19 56</u>, to <u>March 6, 19 56</u>, that I last saw the deceased alive on <u>July 4, 19 54</u>, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<u>Edgar L. Lane</u>				<u>Barclay, Md.</u>			
<b>DATE THEREOF</b>				<b>DATE SIGNED</b>			
<u>Mar. 9</u>				<u>3/8/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>		<b>(State)</b>	
<u>Burial</u>		<u>Sudlersville</u>		<u>Sudlersville, Md.</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>3-8</u>		<u>Edgar L. Lane</u>		<u>Edgar L. Lane</u>		<u>Church Hill, Md.</u>	

# 3250 CERTIFICATE OF DEATH

Reg. No. 100

1. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. BIRTH DATE

15. BIRTH PLACE

16. BIRTH ORDER

17. BIRTH SEX

18. BIRTH RACE

19. BIRTH MANNER

20. BIRTH CAUSE

21. BIRTH MANNER

BUREAU V. 51

MAR 20 1956

RECEIVED

3260

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>A.</u> Middle <u>RATCLIFF</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 10, 1880</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING + COUNTRY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TORONTO, CANADA</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE RATCLIFF</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE THORNDIKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-1202</u>			
				17. INFORMANT Address <u>MRS. CORA M. RATCLIFF, MILLINGTON MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>463X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Widow of the legs -</u> DUE TO (c) <u>Chronic Phlebotrombosis of legs -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>for years</u> <u>for years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 21, 1956</u> , to <u>March 22, 1956</u> , that I last saw the deceased alive on <u>March 21, 1956</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edgar L. Lane MD</u>				ADDRESS (Street, city or town, state) <u>Millington, Md</u>			
PHYSICIAN'S NAME (Type) <u>Edgar L. Lane</u>				DATE SIGNED <u>3.23.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/24/56</u>		<u>CRUMPTON CEM</u>		<u>CRUMPTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway, Millington, Md</u>				24a. REC'D BY REGISTRAR DATE <u>3/23</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1960

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>April 1, 1960</i></p>	
<p>RESIDENCE <i>123 Main St, Baltimore, MD</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>DATE OF BIRTH <i>January 15, 1925</i></p>		<p>AGE <i>35 years</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>EDUCATION <i>High School Graduate</i></p>		<p>OCCUPATION <i>Engineer</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>UNDERLYING CAUSE <i>Arteriosclerosis</i></p>	
<p>DATE OF EXAMINATION <i>April 2, 1960</i></p>		<p>SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>DATE OF ENTRY <i>April 2, 1960</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

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APR 2 1960  
BUREAU V. 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04399

3261

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 20 - about 82 yrs.</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Anna May Smith - Cambridge, Ind.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>560.0 Cerebral accident (hemorrhage)</u> DUE TO (b) <u>Arteriosclerosis general + cerebral</u> DUE TO (c) <u>arterial hypertension left inguinal hernia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>March 27, 56</u> <u>about 5 years</u> <u>about 15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>at Memorial Hospital Eastern, Md.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27, 1956</u> , to <u>March 29, 1956</u> , that I last saw the deceased alive on <u>March 29, 1956</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville</u>		DATE SIGNED <u>March 30, 1956</u>	
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Mar. 31</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Col.</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane - Church Hill, Ind.</u>				24a. REC'D BY REGISTRAR <u>April 6 - 56</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYLAND		2. SEX M		3. AGE 45	
4. OCCUPATION CITY OF BALTIMORE		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. DATE OF BIRTH JAN 15 1910	
7. CAUSE OF DEATH HEART DISEASE		8. PLACE OF DEATH BALTIMORE, MARYLAND		9. DATE OF DEATH APR 10 1956	
10. SIGNATURE OF PHYSICIAN J. H. HARRIS		11. SIGNATURE OF REGISTRAR J. H. HARRIS		12. SIGNATURE OF WITNESS J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF NEXT OF KIN J. H. HARRIS		15. SIGNATURE OF BURIAL OFFICER J. H. HARRIS	
16. SIGNATURE OF CHURCH OFFICER J. H. HARRIS		17. SIGNATURE OF MINISTER J. H. HARRIS		18. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
19. SIGNATURE OF CEMETERY J. H. HARRIS		20. SIGNATURE OF INTERVIEWER J. H. HARRIS		21. SIGNATURE OF SUPERVISOR J. H. HARRIS	
22. SIGNATURE OF ASSISTANT SUPERVISOR J. H. HARRIS		23. SIGNATURE OF CLERK J. H. HARRIS		24. SIGNATURE OF RECEPTIONIST J. H. HARRIS	
25. SIGNATURE OF TELEPHONE OPERATOR J. H. HARRIS		26. SIGNATURE OF MAIL ROOM J. H. HARRIS		27. SIGNATURE OF RECORDS SECTION J. H. HARRIS	
28. SIGNATURE OF IDENTIFICATION SECTION J. H. HARRIS		29. SIGNATURE OF LABORATORY J. H. HARRIS		30. SIGNATURE OF RADIOLOGY J. H. HARRIS	
31. SIGNATURE OF PATHOLOGY J. H. HARRIS		32. SIGNATURE OF BACTERIOLOGY J. H. HARRIS		33. SIGNATURE OF VIROLOGY J. H. HARRIS	
34. SIGNATURE OF PARASITOLOGY J. H. HARRIS		35. SIGNATURE OF ENTOMOLOGY J. H. HARRIS		36. SIGNATURE OF MALACOPHILY J. H. HARRIS	
37. SIGNATURE OF MOLLUSCOLOGY J. H. HARRIS		38. SIGNATURE OF HELMINTHOLOGY J. H. HARRIS		39. SIGNATURE OF MYCOLOGY J. H. HARRIS	
40. SIGNATURE OF FUNGUS J. H. HARRIS		41. SIGNATURE OF ALGAE J. H. HARRIS		42. SIGNATURE OF BOTANY J. H. HARRIS	
43. SIGNATURE OF ZOOLOGY J. H. HARRIS		44. SIGNATURE OF ANATOMY J. H. HARRIS		45. SIGNATURE OF PHYSIOLOGY J. H. HARRIS	
46. SIGNATURE OF MEDICINE J. H. HARRIS		47. SIGNATURE OF SURGERY J. H. HARRIS		48. SIGNATURE OF OBSTETRICS J. H. HARRIS	
49. SIGNATURE OF PEDIATRICS J. H. HARRIS		50. SIGNATURE OF PSYCHIATRY J. H. HARRIS		51. SIGNATURE OF PSYCHOLOGY J. H. HARRIS	
52. SIGNATURE OF EDUCATION J. H. HARRIS		53. SIGNATURE OF SOCIAL WORK J. H. HARRIS		54. SIGNATURE OF NURSING J. H. HARRIS	
55. SIGNATURE OF PHARMACY J. H. HARRIS		56. SIGNATURE OF OPTOMETRY J. H. HARRIS		57. SIGNATURE OF DENTISTRY J. H. HARRIS	
58. SIGNATURE OF VETERINARY MEDICINE J. H. HARRIS		59. SIGNATURE OF AGRICULTURE J. H. HARRIS		60. SIGNATURE OF FISHERIES J. H. HARRIS	
61. SIGNATURE OF MINING J. H. HARRIS		62. SIGNATURE OF METALLURGY J. H. HARRIS		63. SIGNATURE OF CHEMISTRY J. H. HARRIS	
64. SIGNATURE OF PHYSICS J. H. HARRIS		65. SIGNATURE OF MATHEMATICS J. H. HARRIS		66. SIGNATURE OF ENGINEERING J. H. HARRIS	
67. SIGNATURE OF ARCHITECTURE J. H. HARRIS		68. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		69. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
70. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		71. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		72. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
73. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		74. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		75. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
76. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		77. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		78. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
79. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		80. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		81. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
82. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		83. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		84. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
85. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		86. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		87. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
88. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		89. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		90. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
91. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		92. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		93. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
94. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		95. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		96. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
97. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		98. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		99. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
100. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS		101. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		102. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	

RECEIVED  
BUREAU V. S.  
APR 9 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3262

## CERTIFICATE OF DEATH

Reg. Dist. No.

03233  
258

1. PLACE OF DEATH o. COUNTY <u>Green Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Green Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WALRAVEN NURSING HOME</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>TIPTON</u> Last <u>TIPTON</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>about 82</u> yrs.	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Fabius</u>				14. MOTHER'S MAIDEN NAME <u>Alorthea Reseke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Ms. Ken Harris - Chester Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Disturbance</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> (c) <u>General Arterial Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>W 19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 28</u> , 1956, to <u>July 29</u> , 1956, that I last saw the deceased alive on <u>July 29</u> , 1956, and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hite</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sudlersville, Ind. 3/31/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 2</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Kane</u> ADDRESS <u>Church Hill Mt.</u>				24a. REC'D BY REGISTRAR DATE <u>3/31</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar D. Kane</u>	



1

INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03234

## 3263 CERTIFICATE OF DEATH

Reg. Dist. No. 25-2

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>SALLIE L VOSHELL</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 30 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 10-1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Centerville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert F. Vane</u>				14. MOTHER'S MAIDEN NAME <u>Sara Jane Harwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, in, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. V. Deper Centerville Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
490X IMMEDIATE CAUSE (A) <u>Acute Lobar Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>3/29</u> , 19 <u>56</u> , to <u>3/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. D. Fisher</u>				ADDRESS (Street, city, town, state) <u>M.D. Centerville Md.</u>		DATE SIGNED <u>4/2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
24. REC'D BY REGISTRAR <u>4-2-56</u>		REGISTRAR'S SIGNATURE <u>Elmer Armstrong</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Burtin</u>		ADDRESS <u>Centerville Md.</u>	

# CERTIFICATE OF DEATH

Place of Birth  
 Green County  
 Kentucky

Place of Birth  
 Green County  
 Kentucky

26 05 March 1956  
 79 10-18-1916  
 Robert F. Jones  
 Green County  
 Kentucky  
 Green County  
 Kentucky  
 Green County  
 Kentucky

BUREAU V. S.

APR 5 1956

RECEIVED  
 April 5-1956  
 Green County  
 Kentucky



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3264

## CERTIFICATE OF DEATH

Reg. Dist. No. 03235  
254  
252

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Queenstown</u>				TOWN <u>Queenstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ROBERT JOSEPH WEAVER</u>				<u>March 21 - 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Dec-28-1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Hospital orderly</u>		<u>Queen Anne's Is Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Joseph Weaver</u>				<u>Mary Etta Council</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>219-05-6555</u>		<u>Mr. James Boyles Queenstown Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/20</u> , 19 <u>56</u> , to <u>3/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. J. Fisher</u>				DATE SIGNED <u>3/23-56</u>			
M.D. <u>Centerville Md</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 24-56</u>		<u>Chesterfield</u>		<u>Centerville Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/23/56</u>		<u>Elice Armstrong</u>		<u>Edward Davis</u>		<u>Centerville Md</u>	
		<u>Robert M. Aldridge</u>					

CERTIFICATE OF DEATH

James (Name)  
Residence

James (Name)  
Residence

ROBERT JOSEPH WEAVER  
Male White Age 58-60 76

Married Single  
Married Single  
Married Single  
Married Single

Married Single  
Married Single  
Married Single  
Married Single

Married Single  
Married Single  
Married Single  
Married Single

BUREAU V. B.

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3/21- 3/21- 3/21-

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3265

## CERTIFICATE OF DEATH

03236

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne R.F.D.</u>				c. LENGTH OF STAY IN 1b <u>72 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Barclay</u> Last <u>Wessel</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/2/1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William H. Wessel</u>				14. MOTHER'S MAIDEN NAME <u>Liza Ann Travis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-36-0628</u>		17. INFORMANT <u>Bertha Wessel Queen Anne R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Mar. 12</u> , 19 <u>56</u> , to <u>Mar. 12</u> , 19 <u>56</u> , that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Maryland</u> DATE SIGNED <u>3/13/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>				<u>Greensboro, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>		22d. LOCATION (City, town, or county) (State) <u>Ridgely, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-14</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>			

CERTIFICATE OF DEATH

3232

Form with multiple fields for death certificate data, including name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 1

MAR 20 1956

RECEIVED